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MEDICAL ASSOCIATIONS IN INDIA.

BY

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In my paper on "Future of The Medical Profession in Madras Presidency" (*Vide* Journal August, 1937), I have remarked as follows on the question of having only one Medical Association of the Presidency.

"There need be only one Medical Association for the whole province with Branches for the Districts and Taluqs. All the Associations can amalgamate into 'Indian Medical Association'". I owe it to my brother practitioners to explain this conception in full as it is agitating so many minds. At the outset I must point out that I did not mean the present "Indian Medical Association" with its headquarters at Calcutta, as at present constituted. True, many of our District Medical Associations are affiliating themselves with the Indian Medical Association. But we should never do anything at the impulse of the moment and the structure and function of our Associations should be based on the realities of the situation, obtaining in a vast sub-continent as India with its population nearly one-fifth of the world. Moreover fissiparous and centrifugal tendencies must be stubbornly resisted and the Association should speak with one voice. There must be pooling of the resources, no overlapping should be permitted, and the membership fee must be put to the best use possible.

Provinces should be the Units—As I have said, India is a vast sub-continent. India can only be compared to Europe, itself a continent with its several independent states. Even our own presidency, excluding the native states has a population greater than Great Britain. It may be that, just at present, the number of practitioners are very few but the future is full of possibilities, and it may not be long when the number may exceed twenty or even thirty thousands. Morever each province, according to the Government of India Act, is an autonomous and self-governing unit, and Medical Relief and Public Health is fundamentally a provincial subject. Besides, each province has its special medical and allied problems

to solve and a great responsibility rests on the Provincial Medical Association representing the Provincial Medical Practitioners. Yet it is unthinkable that some District Associations, have so readily incorporated themselves with the "Indian Medical Association", without reference to the only provincial non-Communal Association the "South Indian Medical Union". The All India Medical Licentiates Association, Local Branch, the Madras Medical Association representing the few salaried men who can be expected only to plough their lonely furrow, the British Medical Association, South India Branch, a body with no local policy and can only give us the admirable "British Medical Journal" and occasional meetings under official auspices, these are communal or quasi communal, bodies. The South Indian Medical Union is the only one Association what is non-communal. In joining the "Indian Medical Association" without reference to the South Indian Medical Union, the District Medical Associations have not been fair to the only non-communal organization. I have only one personal regret with the policy of the South Indian Medical Union, and that is its taboo of the service men from membership. But this taboo was made in the interest of self preservation because the service men as a body were uncompromisingly antagonistic to the aspirations of the independent profession. When these service men show a real change of heart and merge their identity with the lot of the Independent medical profession, this taboo will certainly not exist and they will form a very important limb of the great Body politic. I should visualize a not distant future when the Independent profession as a whole, will strongly support the claims of the few full timed salaried men who have dedicated their all to the service of the state. Such men, who cannot and should not be expected to have private practice, should be very generously treated and compensated. Till then, till the *prayaschittam* occurs, the union is bound to act in self-defence. I am of opinion, that the Indian Medical Association, as at present constituted, can never deliver the goods to the Independent medical profession. The independent profession should be self-reliant and having established itself firmly, can afford to be generous to their erst-while opponents.

Another reason why provinces should be autonomous, is the existence of the Indian States comprising an area about a third of the Sub-continent of India. Each State has its own special medical problems, which should be left to be tackled by the medical practitioners of the State. For instance, a State like Cochin, with its numerous qualified medical men, may have problems exactly like the British province of Madras. But a State in Rajaputana, may not have any local medical men, and must necessarily have a fully

paid system of medical service. To introduce the honorary system in such a State would be unthinkable. Again in the southern provinces of India, there is no gosha system, and the number of medical women needed must be much smaller in comparison with the North Indian provinces, where an adequate number of salaried women medical officers must be vitally necessary. So the system of medical relief must have a relation to the environment and I, for one, can never commit myself to only one system of medical relief, for all time to come and for all provinces and States. Where the honorary system may be strongly indicated in one province, it may be utterly unsuitable in another province or state. In this province, though we are opposed by the salaried men in the department of medical relief, we, as a profession, have nothing against the full time health officers who are also graduates or licentiates in medicine. Being debarred from private practice they must be kept above want and should be given a reasonable and satisfying scale of pay. The independent medical profession must treat the health department officers as its pet children and should zealously and jealously guard their prospects. If the South Indian Medical Union has views similar to mine, I should not see any reason, why the membership should not be open to full time medical officers in the health department. Such a step will go a great way towards combining the resources of the State health department and the medical profession for combating epidemics which dominate India.

All-India centralization is not advantageous.—Complete centralization of our Medical Associations with a bureaucracy sitting at Calcutta, Delhi or Bombay should not be premitted to dominate the various provinces and States. For a long time to come, if not for all time to come, the Medical Associations shall have to discharge its two functions of (1) putting its medico-political demands (2) improving the art and science of medicine. So long as the medico-political problems vary from province to province and from State to State, the provinces must be the self governing units. Where the problems are of an all India nature, and where the associations are meant for purely professional purposes such as the associations of physicians and surgeons for all India, the provincial units may voluntarily federate and the All-India Association, which I should name as "All-India Medical Federation", can take such of the problems as are beyond the domain of the provinces. It is just the same thing as the different Indian Universities which are really autonomous but can through the "Inter-University Board" meet for common purposes.

Medical Journals.—No Medical Journal published in Calcutta or Delhi can cater to all the provinces and States. Each province or State has got its special clinical and public health problems. Where Bengal has to

tackle with Kala Azar, malaria, Epidemic dropsy etc., Madras has to tackle with Peptic ulcer, buccal cancer etc. A journal published in Calcutta can never get above its immediate environment. The Indian Medical Gazette is virtually a symposium of the work of the Calcutta School of Tropical Medicine. So each province should have its own authoritative organ for both medico-political, clinical and public health purposes.

Allocation of Funds.—The district and taluq associations must be branches of the provincial associations and must be subject to the control, discipline and audit of the latter. There may be primary associations, district associations and provincial associations.

Primary Associations.—Each taluq should have its primary association. The district town should have the status of a primary association.

District Associations.—All the primary associations in a district, together, should constitute the district association. The Madras City should have the status of a district association.

Provincial Association.—All the district associations together should constitute the provincial associations. The executive of the provincial association should be representative of all the districts according to the strength of the associations.

All-India Medical Federation.—Should be a voluntary federation of all the provinces and States and should concern itself with only All-India problems. The membership fee must be uniform and may be at present Rs. 10 per year. Out of this Rs. 5 may be set apart for the province. Rs. 2 for the district association. Rs. 2 for the primary association and Re. 1 as contribution for member, to the All-India federation. If the South Indian Medical Union is reconstituted on this model, it will become a power in this province.

Fate of the British Medical Association.—If the provincial association becomes really democratic, the influence of the British Medical Association will wane. Our Associations should have cultural contact with the parent Association in England but cannot tolerate its domination. We may invite the parent body to hold one of its annual deliberations on Indian soil.

Proceedings of the All India Federation.—Can be reported fully in the provincial Medical Journals. There need not be any centre for the all-India office. Each provincial or State centre, which has the privilege of inviting the all-India federation for its annual or bi-annual meetings, can be the head-quarters for one year or two respectively.

[Medical men in Government service are not allowed to be members of Union. This rule was made to save them from the wrath of the Government. The idea of safe-guarding the interests of the practitioners does not arise.—Ed.]

MIGRAINE.

By

A. V. S. SARMA, M.B.B.S.

In the following, some aspects regarding the etiology of migraine are recorded. The material for the same is supplied by a study of some families, which show the incidence of the disease.

1. Mr. K. R. Naidu, male, 23 years. Gets weekly attacks of sick headache more often on the right side, and also pain in the right arm. Height: 5 ft. 6¾ in. Weight 166 Lbs. Chest 37"—35". Abdomen 33½". Father died at 45 due to asthma or tuberculosis(?). Mother is living and is of rheumatic temperament, and also gets sick headache. Patient's sister (age 25) gets migraine, and bodily pains. Patient's brother (20 years) has a rheumatic diathesis. Patient's two other sisters (ages 18 and 13 years) are quite healthy. Patient's cousin (male 36 Years) suffers from asthma.

The patient under study had enteric fever 9 years ago. He grew obese after the fever. Had gonorrhoea 2 years ago, which was promptly treated.

Clinical findings :—

Pulse rate :— { sitting : 70 per minute.
standing : 70 per minute.
after slight exertion : 90 per minute.

Blood pressure :— { Sitting : 135/80 mm. of Hg.
standing : Do.

Heart :—Upper border at 3rd space. Right border at mid-sternal line and the left border at the mid-clavicular line. First sound is rough in its commencement and the second is accentuated in all areas. A soft systolic murmur is heard over all areas. The systolic murmur at the mitral is conducted to the anterior axillary border.

Special points :—This patient gets attacks of migraine more frequently after his febrile illness (enteric ?). Overwork by day or waking up at night starts an excruciating pain in the eye and side of the head on one side.

Urine is clear. Acid to litmus. Methylene blue test gives colouration of urine at the end of 1 hr.

2. Mr. T. R. Swami, 25 years. Has migraine on the right side. Gets dimness of sight in right eye. Nausea precedes the headache, and pain is relieved if a vomit results. Gets also pain along one half of the body—more often on the right side of the body. The pain started in 21st year. From the 24th year the hemicranial attacks are more frequent and sometimes the pain in the body deprives the patient of sleep at nights. The patient had fever and joint pains in March 1937—rheumatic fever ?. At the time of examination, the patient shows a harsh pre-systolic murmur and soft systolic murmur at the mitral area. After the fever, the sick headache occurs regularly every week. Before the fever, the patient experienced migraine once in 2 or 3 months. Urine shows no sugar or albumin.

3. Miss Kuppu, female, 12 years. Gets sick headache regularly every fortnight. The patient's mother has marked myocardial debility and also gets migraine. The mother's family seems to be free from a history of migraine. She lost many children from infantile liver, a fact worth remembering. This patient gets attacks of transient loss of vision in the right eye and right-sided headache and sickness so as to keep her in bed on most occasions. Responds well to aspirin.

Urine is clear. The praecordial region does not show auscultatory signs suggestive of heart disease.

4. Mrs............age 45 years. C/o Mr. N. R. I.

This lady has palpitation of the heart alternating with migraine. Her daughter recently developed pulmonary tuberculosis (active condition), and a child of this patient has had infantile liver.

5. Mrs. V. V. I. age 30 years. Gets sick headache which alternates with parecordial pain. Maternal uncle of this patient had asthma. Urine is healthy.

6. Mr. M. R. K. age 35 years. Gets migraine rarely. Patient's mother died of paralysis. Two brothers succumbed to pulmonary tuberculosis. The son of a sister of this patient has chronic mania. Two children of this patient (Mr. M. R. K.) died of infantile liver. Urine shows a trace of sugar but no albumin. Blood Wasserman is negative.

7. Mr. G Subbaiya, age 40 years. Gets sick headache from 20 years. His father had this complaint. The patient has a damaged heart—mitral first sound weak, and there is a soft systolic murmur heard all over the praecordium, but best appreciated in the mitral area. B. P. 120/90 mm of Hg. Urine is clear. Methylene blue test gives colour in urine after 2 hrs. A child of this gentleman has infantile liver.

8. Mr. M. Subba Reddi, 40 years. This person has a damaged myocardium. Gets sick headache. Urine is clear. Methylene blue test gives colour in urine after 1½ hours.

9. Mrs. Sreenivasan, age 33 years. Hemicrania started after puberty and disappeared after bearing 2 children. Now in its stead she gets asthmatic paroxysms. The patient's maternal side is asthmatic and her son is also an asthmatic.

10. Mr. M. Arumuga Chettiar, 40 years. Gets asthmatic attacks alternating with sick headache. His father used to have only sick headache. Blood Wasserman is negative. Urine is clear. B. P. 130/70 mm of Hg.

11. Mr. T. M. Sami, 19 years. The heart condition is similar to that of a rheumatic pancarditis. The patient gives a history of fever and joint pains 1½ years ago. There is no history of asthma or migraine or epilepsy in the family. After the rheumatic fever (?), the patient is getting sick headache. But the point is, his sisters and brother have asthma or sick head ache. The patient's father is an alcoholic.

Concluding Notes.

A point worthy of note is that Mr. F. (cf. Migraine—Journal of South Indian Medicine, October 1937) gets urticaria. This patient and Mr. K. R. Naidu get attacks of abdominal colic simulating appendicitis but these attacks are easily brought down with 15 minim doses of Benzyl Benzoas. In Mr. F. there is a cardiac irregularity.

From a study of the above cases, there emerges an intimate relationship of migraine with rheumatic disease, hepatic hypofunction, tuberculosis, asthma, insanity, and alcoholism.

The rheumatic poison circulating in the blood seems to damage either the cerebral cortex or the cerebral arteries themselves in some way or other, and thus to pave the path for the action of one or more of the many well-known existing factors responsible for the onset of migraine. An intimal

thickening of blood vessels or actual neural damage or an interstitial fibrositis (rheumatic nodules), singly or in unison might be possible.

Vitamin C has been useful in averting attacks in 2 cases. In women having migraine, dysmenorrhoea was also noticed and when they had treatment with Antuitrin—S for the latter complaint, migraine seems to have been mitigated in intensity and its frequency has been averted also.

(*The Methylene blue test* :—This consists in the oral administration of 3 grains of methylene blue in a gelatine capsule on empty stomach. Greenish colouration of urine due to the excretion of the dye in urine appears at the end of one hour in normal adults. In patients with hepatic disease or dysfunction the colouration is delayed to a later time than 1 hour. In doing this test cases having no renal trouble only have been observed.)

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GLEANINGS FROM MEDICAL LITERATURE

23. CONSERVATIVE TREATMENT OF CANCER OF THE BREAST.

GEOFFREY KEYNES,

B.M.J., 2-10-1937.

Although the main principles of Halstead's radical operation for Cancer of the Breast have become more or less standardised, most surgeons who have followed up their patients after performing the radical operation are gravely dissatisfied with the results.

Encouraged by the results of irradiation in cancer of the tongue, mouth and fauces and in cancer of the cervix uteri attempts have been made to find out whether irradiation might be used to mitigate or possibly abolish the necessity for so drastic a form of treatment as the radical operation.

The statements that cancer of the breast is not a radiosensitive neoplasm and that satisfactory irradiation of the contents of the axilla is impossible are questioned: this opinion being based on the late results of irradiation as presented here.

It is maintained that patients with early carcinoma will do just as well after local removal of the breast as after the more extensive radical operation, while if the axillary lymph nodes are extensively infected dissection of the axilla would be positively harmful. The investigation of J. H. Gray under the inspiration of Prof. Woollard would appear to discount the theory of centrifugal lymphatic permeation, the correct inference being that carcinoma cells pass to the nodes as emboli, usually without forming intermediate points of growth.

The treatment advocated is:

(1) implantation of long needles each containing 3mg. of radium element placed in a parallel series from each side and overlapping in the centre.

(2) irradiation of axilla with 4 to 7 needles.

(3) 3 short needles above the clavicle.

(4) one needle in each of the upper 3 or 4 intercostal spaces: these cause pain and may be omitted except when the disease has started in the inner part of the breast.

No dissection of the axilla is ever done and surgical treatment—which has preceded irradiation and if adopted at all—is as conservative as circumstances permit.

The results of irradiation and surgery have been compared statistically by grouping the cases as follows:

Group I. Disease apparently confined to the breast.

Group II. Disease apparently confined to breast and axilla.

Group III. Disease advanced or inoperable.

The only category of really curable patients is that included in group I which is therefore most interesting from the clinical view point. This group under orthodox treatment would be considered eminently the field for radical surgery: yet the present figures show that the survival rates after irradiation are higher than after radical surgery. This is probably to be explained by (1) the absence of operative and post-operative mortality after irradiation. (2) the absence of interference with the lymphatic system of the axilla which probably favours dissemination.

To these figures must be added the advantage of the avoidance of the hideous mutilation following surgery, the comparitively little limitation of movement and strength in the arm. There is also the psychological aspect. The elimination of the dread of an extensive operation would probably result in many women seeking advice earlier in the disease than they would otherwise do.

M. K.

24. URINARY TUBERCULOSIS, ITS SYMPTOMS AND SIGNS.

T. E. HAMMOND,

The Practitioner—August 1937.

The intimate relationship between the urinary organs and the genital tract in man makes it not uncommon for both systems to be involved at the same time. Tuberculosis of the urinary tract extends to the genital organs in a large proposition of men while infection of the genital tract spreads to the

urinary organs only rarely and as a terminal event. In women tuberculosis of the genital tract follows urinary tract infection but rarely. It is important from the point of view of treatment to differentiate the sequence of the infections.

Symptoms : Rarely does genital or urinary tuberculosis lead to much impairment of health in its early stages. When the disease is confined to the kidney there are generally no symptoms and only occasionally is there haematuria, frequent micturition and lumbar pain, even with extensive disease. No haematuria should be regarded as essential, until guinea-pig inoculation has proved negative.

The bladder offers a marked resistance to all kinds of infection, consequently though the disease may be active in the kidney there may be no vesical symptoms whatever. Once the bladder is infected symptoms become very pronounced and even out of proportion to the extent of vesical involvement. Frequency, urgency, pain and terminal haematuria are present. Often the symptoms are intermittent and may disappear for months on end. There is no doubt that this is due to the great healing powers of the vesical mucous membrane. Sometimes it results from the tendency for obstruction to occur in the ureter as a result of which disease products no longer enter the bladder. Often the symptoms are aggravated by hexamine so that in a patient whose symptoms are aggravated by hexamine tuberculosis may be assumed until proved not to exist. A certain amount of sexual irritability may be expected when the prostate is involved.

A slight loss of weight is not unusual, but lassitude, night sweats and evening temperature are often absent, so that if the patient has been sent to a sanatorium prior to operation his general condition may be so good as to excite the comment that it is those who are about to take part in the operation who look most ill! In fact the presence of marked constitutional symptoms should arouse suspicion of either secondary infection or a tuberculous lesion in some other organ as well, such as the lung.

The diseased kidney becomes enlarged if there is obstruction in the ureter and only a small percentage of these enlarged kidneys are palpable, and tenderness is rarely found in the lumbar region. Though the ureter at the time of operation is found to be definitely thickened very rarely can it be felt on palpating the abdomen or on rectal examination. But in women the ureter passes close to the lateral fornix and on vaginal examination some thickening may be felt in about 20% of cases.

M. K.

25. TREATMENT OF DYSMENORRHOEA.

L. J. STACY AND R. SHOEMAKER,

American Journal of Obstetrics and Gynaecology, January, 1937.

The authors report a study of 262 cases of dysmenorrhoea from the Mayo Foundation; 132 were single women. Pregnancy had failed to cure 47 out of the 130 married women. Of these, six gained relief after treatment plus a second pregnancy, but six remained as before. Psychic and fatigue factors were noted in 82 cases. The results are tabulated according to the type of treatment:

(1) *Drugs*: Antispasmodics, analgesics and sedatives, chiefly benzyl benzoate, barbiturates, belladonna, and calcium lactate, alone or in combination. After a course of such treatment 51 per cent showed benefit, some permanent.

(2) *Endocrines*: Alone or combined with drugs, at least for a time, primarily for cases showing menstrual irregularities. Of these, 60 per cent gained relief, relapses occurring unless treatment was maintained or repeated in an uncertain proportion. Ovarian extract, oestrin (progynon), placental hormone (emmenin), and sistomensin (luteo-lipoid of corpus luteum) are separately reported upon, the last one being chosen when excess loss as well as pain was present. Complete relief was obtained in 5·4 per cent, with improvement in 55 per cent, but these endocrine preparations might have had very little effect.

(3) *Radiation therapy*: Irradiation of pituitary or ovaries was used in five cases with relief, but the method is for expert radiologists only. Radium in doses to induce temporary amenorrhoea or full menopause, applied in 16 selected cases, was successful in 69 per cent.

For patients with disabling and otherwise incurable dysmenorrhoea resection of the presacral nerves is a possibility, relief being considerable and generally complete.

K. R. C. H.

26. DIAGNOSIS AND TREATMENT OF GASTRIC AND DUODENAL ULCER

Leys: LANCET,

(May 22, 1937).

An ulcer may not give rise to pain, vomiting, or alteration of appetite, and there may be no tenderness on clinical examination. The test meal may

show a normal or low percentage of acid, or free acid may be absent, the benzidine test may show no occult blood either in the test meal or in the stool. It is important, therefore, that every patient with symptoms of indigestion persisting for any length of time should be submitted to a competent radiological examination. Silent bleeding is an important factor and causes hypochromic anaemia. A patient with long standing anaemia and indigestion at any age and a symptomless patient with anaemia and free hydrochloric acid present in the stomach, both should be deemed to have gastric or duodenal ulcer till they have been excluded by careful examination from all view points. Local tenderness is elicited satisfactorily only under the fluoroscopic screen and may not be present on ordinary palpation with the patient in bed.

The fractional test meal gives confirmatory evidence. The acidity is rarely more than 0·2 per cent in gastric ulcer and may be absent in a small number; it is more, over 0·3 per cent, in duodenal ulcer and never completely absent.

The presence of blood is significant and should not be considered traumatic unless absent in further examinations. The diet does not seem to give false positives even if it contains meat, fish, or vegetables. Xray evidence of healing is very valuable and also reliable as it coincides with disappearance of symptoms and physical signs and occult blood in the stools, while the *vice-versa* does not always occur. The rapidity of healing is sometimes astonishing.

The incidence of gastric to duodenal ulcers in the author's series has been 2:1 which is quite contrary to the usually accepted ratio of 1:4. This ratio might have been due to greater prominence being given to surgical experience.

Treatment:—It is important to note that (1) healing takes place quite often in a gastric ulcer without any special treatment except attention to diet. (Milk is a common factor in these diets).

(2) Institutional treatment is superior to home treatment even if it is very thorough.

(3) Bed relieves the pain very quickly even with an ordinary diet.

(4) Alkalies and bismuth have no effect on the symptoms or the size of the lesion although they appear to relieve the pain of duodenal ulcer.

No special line of treatment, including histidine appears to have any influence on the course of the disease. The type of occupation has not given any clue except that stress, hurry and anxiety may play a minor part.

Diet may afford a promising line of enquiry, and should be closely studied. Vitamin deficiency may be a factor—A as well as B—and adequately balanced diet is always valuable. Large doses of vitamin A may help. Iron in adequate doses from the start form an integral part of the treatment and the haemoglobin must be brought up to 100 per cent. Blood transfusions and not surgery are valuable for haemorrhage. Surgery has no place except in the rare instances of perforation and gross deformities and persistent haemorrhage.

K. R. C. H.

27. MODERN METHODS OF TREATMENT OF CLUB-FOOT.

E. P. BROCKMAN,

B. M. J., 18th September, 1937.

Congenital Club-foot is due to a congenital dislocation of the head of the Astragalus, due to an atresia of the socket into which the head of the astragalus normally fits and the deformity is the result of an intrinsic cause. If the deformity were due to outside pressure, it should be a simple matter by exerting a similar pressure in the reverse direction to correct the deformity and to hold it so till the child is able to do so by its own muscular effort. This does not obtain in practice.

Treatment in the infant: Repeated forcible manipulation and fixation in corrected position by plaster strapping is a poor method. It needs frequent repetition, hurts and frightens the child, is rather brutal, has frequently to be interrupted because the skin of the foot becomes sore and last and most important, it is useless once the child becomes of any size as the patient is able by the contraction of the muscles to pull the foot round despite the strapping. Besides these the foot becomes stiffer each time it is manipulated and the muscles of the leg become more and more wasted as the result of the prolonged periods of fixation and once they become really wasted and hardened they never again become supple or properly developed.

The splint invented by Denis Browne avoids nearly all these troubles. Perhaps several manipulations are necessary to apply the splint in the first instance but thereafter the splint can be reapplied without any difficulty, a little more correction being obtained every time by gradually rotating the foot outwards. The adduction and inversion improve and the small drawn up heel descends without any trouble, the child probably stretching the tendo-achilles by gradually pushing against the splint.

Tenotomy or elongation of the tendo-calcaneus to correct residual equinus is not advisable.

The criternion of cure is "a foot with no adduction or inversion, the presence of a hallow upon the outside of the foot in the position previously occupied by a bony mass the head of the astragalus and the ability of the child to evert and dorsi-flex the foot well above a right angle."

Even if this is obtained one cannot promise that the deformity will not relapse. When it does, it denotes a spurious correction, the deformity having been masked by a false correction of the fore part of the foot.

Open operation : The results of open operation are in some cases quite good from a functional point of view, but not as good as the ones treated by conservative methods only. There is very real danger of the foot becoming valgus and boat-shaped if the open correction is easy and once such a result has occurred nothing short of an arthrodesis will remedy it.

A great many patients upon whom an open operation has been carried out return sometimes years later with a relapsed and rigid foot. In these the sub-astragaloid and mid-tarsal joints are full of fibrous tissue binding the opposing surfaces together. The foot is often much thicker in the mid-tarsus and there is a tendency for persistant equinus to remain.

Bone operations : When all other methods of treatment have failed an arthrodesis of the sub-astragaloid and mid tarsal joints with removal of a sufficient amount of bone is the best and most lasting method of treatment. In fact if there is any doubt about doing an open operation arthrodesis is probably the better line of treatment. Astragalectomy is to be condemned while osteotomy of the lower end of the Tibia is simply the production of one deformity to hide the existence of another.

M. K.

CORRESPONDENCE.

MADRAS MEDICAL COUNCIL.

SIR,

Your leading article on "Madras Medical Council" in the October 1937 issue, deserves full attention by the ministry concerned. After your analysis of the functions of the proposed medical council, the creation of special seats for professional Colleges, the Universities, and other interests, are an indication of common human nature which finds it difficult to get out of the age long rut. It also shows that the authorities cannot trust the medical practitioners to the extent they themselves were trusted by the mass of voters literate and illiterate, who put their votes in the yellow boxes in the recent elections. The medical practitioners are the most enlightened of the communities, they have received general and special scientific education and they have the most liberal views. It would be impossible to imagine that the democratic ministry controlling our destinies would try to deny the same democracy to the men and women of a noble and learned profession. It would be foolish to imagine that there would be chaos if all the members of the Medical Council proposed, are purely elected by all the medical men and women practising in the Presidency, enrolled in one register, in alphabetical order. The method of election may be by proportional representation by means of single transferable vote. There should be absolutely no reservation on any account, such as race, nationality, religion, sex or academic qualifications. When millions of literate and illiterate voters can trust a party ministry to control its destinies, a few thousands of medical practitioners can certainly trust their elected representatives to control their ethical and professional standards.

MADRAS,
Nov. '37.

E. S. G.

JOURNAL OF SOUTH INDIAN MEDICINE

NOVEMBER, 1937.

TUBERCULOSIS.

We have on former occasions drawn the attention of the public and the Government to the increasing incidence of tuberculosis in this Presidency. We have also suggested some of the methods by which a good deal could be done to mitigate this evil. We have not found any great effort on the part of the Government or the public to organize the means to combat this danger. But we realize at the same time the difficulties and limitations of the Government. We are surrounded on all sides with problems each one of which will fully tax the financial resources of countries far more fortunate in wealth. The enormous ill-health and death due to the ravages of malaria is ever present. Leprosy is more and more in evidence. There is at present a certain Leprosy-mindedness in this province. This is all to the good. But it is not enough. There is the increasing cry of cancer patients. And over and above all these, there is the periodic devastating epidemics like Cholera, small-pox and the dysenteries. Here is more than enough to create despair in the minds of the mightiest States. And even the most socialistic Government cannot do much to eradicate these diseases in reasonable time. Granted all these difficulties, no live State can afford to sit with folded hands in the midst of such distress.

Many of the existing diseases have assumed such frightful proportions for want of timely measures. Though tuberculosis of the lungs and other organs is rapidly increasing in this country, it is yet chiefly met with in the towns. The villages have upto now been relatively free from the disease. Widespread as the incidence is, it is still in controllable propor-

tions. We therefore refer to this disease once more so that the usual mistake of delay may be averted and that the narrow resources of this country may be applied to limit the spread if we cannot altogether prevent it.

We are happy to note that at the last Conference held in London to review the various measures adopted in the British Empire to combat tuberculosis, many experienced physicians referred in detail to the various aspects of the disease in this country. The magnitude of the task has made some of them rather pessimistic. Inspite of it, many of the suggestions made at the Conference are worthy of note. Hardly anything has been done in the way of an accurate survey of the incidence and course of the disease in this country. This is very important and it requires the enthusiastic co-operation of all medical men and health organizations to obtain even reasonably accurate data on this point. This need not entail large funds. But it certainly requires a good deal of willingness to co-operate and to seek co-operation. While this survey is done, the need for hospitals to accommodate the tuberculosis patients and the need for a very large number of well equipped medical men to look after them are very urgent. To combat tuberculosis, care and after-care of the patient are all important. There is a tendency on the part of many people to feel that the creation of a few sanatoria in salubrious climate and the establishment of a few tuberculosis colonies for the after-care of these patients will make this country up-to-date in the matter of anti-tuberculosis work. They also feel that a number of tuberculosis dispensaries or clinics for the purpose of early diagnosis and advice will meet the situation. It does not require much argument to show how wrong are such ideas.

The diagnosis of tuberculosis is not very difficult. At least cases which are a danger to society are easy enough to spot. And our medical practitioners can be trusted to do that quite satisfactorily. But after diagnosing the case as tuberculosis, what is the practitioner or the patient to do? Even in rich countries, they find that hospitalization of such cases offers the only means of

arresting the disease. The facilities for treatment in hospitals are very poor indeed in this province. We think conditions are not very different in other provinces. The number of beds specially intended for accommodating tuberculous patients is too inadequate to believe. And the general hospitals are usually so over crowded that apart from the difficulty of beds, it would be dangerous to admit patients with pulmonary tuberculosis in these institutions. The first objective therefore, in any anti-tuberculosis work in this country should be the provision of a large number of beds for the tuberculous patients.

In pressing for more hospitals, we are not forgetful of the benefits of sanatoria. But sanatoria are not cheaper. And they have the further disadvantage of being far from the homes of the patients. And the patients are generally averse to being far away from their kith and kin. This is an aspect which is well worth remembering by those in authority when they plan for such institutions.

Equally important as the beds, is the large number of well equipped medical men thorougly familiar with all aspects of the disease. We need them for manning dispensaries where they could diagnose and advise early cases. They are necessary to continue the treatment of those who after the necessary stay in the hospitals are referred to these centres. They are required to carry on propaganda and prophylaxis. With the provision of these urgent needs, some progress might be anticipated in anti-tuberculosis work. We earnestly hope that some early effort will be made in this direction.

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ASSOCIATION NOTES.

SOUTH INDIAN MEDICAL UNION.

Minutes of the ordinary general meeting of the Union held on Monday the 15th November 1937 at 6 p m. at 32, Broadway, Madras.

The following members were present :—

1. Dr. M. Subramania Iyer.
2. „ T. Satakopan.
3. „ B. M. Sundaravadhanam.
4. „ E. V. Srinivasan.
5. „ V. D Nimbkar.
6. „ M. Krishnamurthi.
7. „ V. C. Sudarsanam.
8. „ T. Venkateswara Rao
9. „ P. S. Varadachari.
10. „ P. S. Kuppuswami.
11. „ P. Govinda Rao.

Dr. V. D. Nimbkar was in the chair. He vacated it in favour Dr. M. Subramania Iyer who came a little later.

1. The *Ad hoc* Committee appointed at the general meeting of the Union held on 19th August 1937, submitted its report to the meeting and it was considered. After discussion the Union approved of the Committee's findings with a few modifications.

2. With reference to para 2, the following suggestions were put forth by members.

Dr. Govinda Rao said that Medical men in Government service should not engage in insurance medical work and the official consultants should see patients only when referred by other practitioners. Highly paid medical officers should not be allowed to continue to be medical advisers to commercial firms. The practice of allowing Government servants to get free treatment in hospitals should be curtailed.

Dr. Nimbkar said that hospital authorities should more carefully scrutinize patients admitted into the hospitals with reference to their status and income.

3. With these suggestions the Union approved the recommendation of the Committee and the following resolution was moved from the chair and accepted.

Resolved that having considered the report of the *Ad hoc* Committee and the suggestions of the members present, a suitable representation on the necessary points be addressed to the Government at an early date.

4. The meeting then proceeded to consider the proposed amendment of the Madras Medical Council Act. The Union feels that the President of the Council should be elected from the commencement and secondly that with reference to the seats thrown open for election by the registered practitioners, the methods of single transferable vote should be adopted.

With a vote of thanks to the chair the meeting terminated.

A meeting of the Committee appointed at the General Meeting of Union held on 19th August 1937 was held at 7, Ritherdon Road, Vepery, on Friday the 3rd September 1937 at 5 p.m.

All the members of the Committee were present.

The Committee considered the points raised in the paper of Dr. E. S. Gopalan, namely 'The Future of the Medical Profession' in the Madrás Presidency.

1. The Committee unanimously agreed about the desirability of a uniform standard of education for practitioners of modern Medicine.

2. As to the question of preventing salaried Government Medical Officers from private taking practice, the following suggestions were considered by the Committee, viz :—

(*a*) That salaried Medical Officers of the Government employed in the City of Madras or Headquarters towns where a large number of qualified medical practitioners is available should not engage in any private practice.

(*b*) Where the help of senior Medical men is sought by practitioners or the public, such officials should limit their non-Government work strictly as consultants only.

(*c*) Salaried Medical Officers of all ranks should be posted to places where the people are in need of medical relief, but where it is not practicable for practitioners to settle down. In fact, the Government should more and more use their salaried staff to carry relief to places where the people cannot otherwise get medical relief,

(*d*) Professors and Lecturers of Colleges and Schools who are by statute allowed practice should limit their services to their specialities. It is indeed anamalous that they should engage in general practice.

(*e*) Abuse of privileges by Government Medical Officers should be more strictly scrutinised.

3. To be considered later.

4. The Committee desires this question to be left over to be considered later.

5. The sense of the Committee is that it is not practicable. But the profession could consider this question leisurely.

6. The Committee feels that the question of 2 years' course is not necessary.

7 & 8. The Committee commends to the consideration of the profession the desirability of forming Medical Libraries and organising museums in each district

9. The question of post-graduate education, the committee wanted some more time to consider and put forward definite proposals.

10, 11 & 12. The Committee do not feel called upon to offer any remarks on the suggestions.

13. The Committee will leave to the individual practitioners consideration of research in Ayurveda.

14. The Committee do not feel at present the need for a College of Physicians and Surgeons.

15. To be considered in connection with the Rural Medical Services.

16. The Committee do not agree to the suggestion for the increased representation in the legislatures of the country by setting up Medical men as candidates on the joint suffrage of the Medical Practitioners and the most progressive party in the province.

17 & 18. The Committee considers that this question of one association and annual meetings should be left to time for gradual evolution.

The meeting was adjourned to a future date.

RAMNAD DISTRICT MEDICAL ASSOCIATION

The November meeting of the Ramnad District Medical Association was held on the 20th November, 1937 at the S. M. S. High School, Karaikudi with the President of the Association Captain B. Dayanada Rao in the chair.

The minutes of the combined meeting of Ramnad District, Tinnevelly District and Madura Medical Associations held at Madura on the 23rd October, 1937 read by the secretary was adopted and the secretary was authorised to communicate the resolutions passed at the combined meeting to the press and the authorities concerned.

The secretary announced that the Managing Committee which met earlier that evening recommended :—

1 This Association be made a Branch of the Indian Medical Association ; Also the members may be classified into two groups, one—Regular Members who become automatically members of the Indian Medical Association ; two—Associate Members who are only Associate Members of the Ramnad District Medical Association without vote in business matters.

2. This Association be made into a branch of the Indian Medical Association forthwith and the secretary is authorised to remit Rs. 8 per paid members being the half-yearly dues to the Indian Medical Association and also communicate the addresses of these members.

3. This Association requests the Government that in the new Madras Medical Council Act to be passed by the Madras Legislature, in the elected members to the Council proper and proportionate representation of the following groups of practitioners—1. Independent Medical Practitioners, 2. Rural Medical Practitioners and 3. Municipal and Local Board Employees be given in the election according to their electoral strength.

After some discussion these recommendations were approved.

T. S. Shetty, K. S. Srinivas and such other members of the Association, who may attend the coming conference (XIV All India Medical Conference) at Madras were declared as Delegates representing this Association at their cost.

An interesting case operated for a malignant tumor of the orbit by T. S. Shetty was demonstrated and the case report read ; After the discussion on this case the meeting terminated with the usual vote of thanks.

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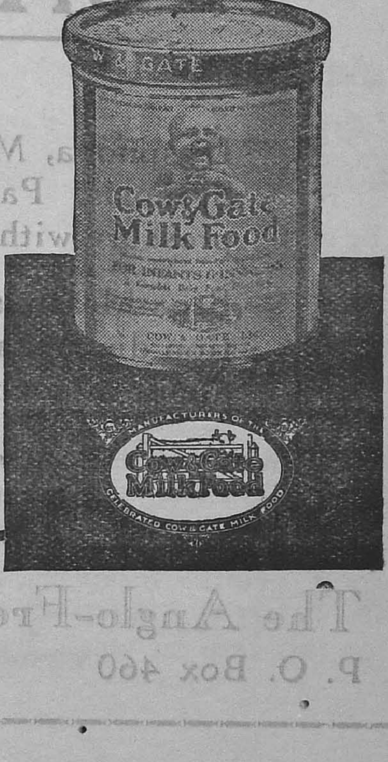

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The combined meeting of three Associations the Ramnad District Medical Association, the Tinnevelly District Medical Association and the Madura Medical Association was held at the Sourashtra High School, Madura on the 23rd October, 1937.

There were 125 medical men and women assembled of whom 3 were from Trichinopoly who responded to the kind invitation of the Madura Association, 33 from Ramnad District, 13 from Tinnevelly District and the remaining were from Madura District.

The proceedings commenced at 3-30 p.m., with music on Veena by Miss Kamu Ammal. After tea, the meeting began at 5 p.m. The President of the Madura Association Rao Bahadur S. Padmanabha Sarma welcoming the colleague from the neighbouring districts of Ramnad and Tinnevelly proposed Col. Sastri, I.M.S. President of the Tinnevelly Association to the chair. The minutes of the last meetings of the three Associations were read by the respective secretaries and adopted.

The following case reports were given : —

Strangulated hernia with removal of gangrenous gut and making foecal fistula and later closing the foecal fistula ; specimens of removed appendicular disease ; distended uterus with absence of vagina due to retention of menstrual discharge—in this case complete hysterectomy with removal of ovaries was advocated ; and tetanus ; and another case of lockjaw due to carious tooth simulating tetanus.

There was discussion on these cases.

The following resolution moved by T. S. Shetty of Ramnad District and seconded by P. A. S. Raghavan of Trichinopoly was carried unanimously by the gathering.

" This combined meeting of the Ramnad District, Tinnevelly District and Madura Medical Associations heartily approves the action of the Ministry in abolishing the L. M. P. Courses and converting the Madras Stanley Medical School into a College."

The next resolution moved by T. S. Venkataraman of Madura and seconded by V. Sriramachandran—" The members of the Madura Medical Association resolve that the Madura Medical Association be converted into a Branch of the Indian Medical Association and that the Governing Body be requested to take necessary steps in the matter "—was after a speech from the Chair passed unanimously by the Madura members.

Papers on Nutrition by Dr. H. S. Thomas of Madura and on "The Incidence of Malaria in the Cumbum Valley" by R. Krishnaswami were read.

The Chairman before closing the meeting called on Dr. T. S. Shetty to move the following.

"This meeting of the Ramnad and Tinnevally District and Madura Medical Associations request the Ministry of Public Health to the Government of Madras to encourage the Indian Medical Industries by insisting the Medical Stores Depot to purchase their requirements from Indian Made Goods."

After a speech from the Chairman regarding the rapid and marked progress in the quality of Indian Manufacturers which compare favourably with other foreign products, the resolution was put to the house who adopted it with acclamation.

In winding up the meeting Col. Sastri remarked that the gathering was very unique on account of its large number and the Associations of four southern districts taking part in the function and hoped that such gatherings will take place every now and then.

The guests were all entertained to dinner after which members of the Madura Medical Association with Dr. T. S. Sivaramakrishnan of Ramnad District and the help of Mr. P. Krishnaswami Sastri and other friends staged a Tamil adaptation of Molliere's Mock Doctor, which was appreciated by the audience which included the public of Madura.

The Secretary of Madura Medical Association thanked those who helped in the successful staging of the drama and the guests. Dr. M. S. Rajam of Madura thanked the doctors who contributed liberally for the functions and those that responded to their invitation, thanked the lecturers of the evening for the valuable and instructive papers and the public who attended the drama.

Captain B. Dayananda Rao replied in appreciative terms, while Col. Sastri spoke in Telugu and Rao Bahadur K. Devaji Rao, on behalf of the public of Madura thanked the Madura Medical Association for the dramatic show.

With the final scenes of the drama the proceedings came to a close by about midnight.